Special issue

Title: Intimacy, morality and precarity: Globalisation and family care in Africa - insights from Ghana

Editors

Dr Ursula M Read*

Department of Global Health & Social Medicine

School of Global Affairs, Faculty of Social Science and Public Policy

Bush House North East Wing Room 3.1

King's College London

Strand, London WC2R 2LS

Email: ursula.read@kcl.ac.uk

Professor Sjaak van der Geest

University of Amsterdam

Email: s.vandergeest@uva.nl

*corresponding author: Ursula Read

Introduction:

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Abstract

With the rise of non-communicable diseases such as diabetes and cancer, as well as increased longevity, the role of the family in care is of increasing importance to health policy and interventions globally. In low-income settings in sub-Saharan Africa, where health and welfare systems are under-resourced, 'task-shifting' to community health workers, volunteers and family members is sometimes proposed to fill the gaps. However migration, urbanisation and widening social inequality have had a profound effect on household structure and the capacity for care. This special issue focuses on Ghana, a country which exemplifies these processes. The contributing papers examine the impact of social, structural and economic changes on practices of family care for a variety of conditions across the life course in urban and rural locations.

Introduction

In one of the formative anthropological texts on globalization, Arjun Appadurai (1996) made the following observation:

> It takes only the merest acquaintance with the facts of the modern world to note that it is now an interactive system in a sense which is strikingly new. Historians and sociologists […] have long been aware that the world has been a congeries of large-scale interactions for many centuries. Yet today's world involves interactions of a new order and intensity. (p.27)

For Appadurai, this new globalization arose from the 'technological explosion' in transport and technology (p.29). He was writing this at the beginning of the internet age since when international communication technology has expanded in ways which few scholars of globalization could have anticipated.

As Appadurai observes, these intensified forms of global exchange prompt new examination of old anthropological questions about the impact of social change on the family, 'the classical locus of socialization' (Appadurai 1996:43). Such questions were of increasing concern to early anthropologists of Africa as the legacy of colonial interference became visible, and the colonial project itself came under scrutiny. In the 1950s, after a long period attempting to catalogue 'native' African cultures and how they functioned, anthropologists shifted their attention from static description to the dynamics of those cultures. Malinowski, one of the founders of the functionalist tradition, urged his colleagues to involve themselves in the changes that took place on the African continent. *The Dynamics of Culture Change: An Inquiry into Race Relations in Africa*, which appeared in 1945 after his sudden death, was one of the first publications of this new perspective (Malinowski and Kaberry 1945). Malinowski was concerned with the impact of 'culture contact' on African societies *and* on Europeans in Africa to determine how best to continue the project of 'Western civilization' (p.12). Fifteen years later Lucy Mair (1960) published an influential reflection on the changes she had witnessed in Africa:

> To a superficial observer changes in mode of life are measured by what can immediately be seen – Western dress, bicycles, lorries and Jaguar cars, school books, newspapers, the queue at the polling station, the judge on the bench, the legislator making his speech in a European language and the clerk recording it. Such an observer might be tempted to measure the extent of changes in African society by the

> number of these items. But it is the kind of change in social relationships of which these are the signs that interests the student of society (p. 447).

She describes these changes in terms which express fears of the substitution of the economic for the social:

> … throughout Africa south of the Sahara production for exchange was far less important than production for subsistence. Valuable goods changed hands less often for economic than for social reasons. Those who rendered services, whether to neighbours or to persons in authority, were rewarded rather than paid, and the obligation to make due return was moral rather than contractual. The duty to give, and the claim to receive, economic services were matters of social relationships… (p. 448).

One year after Mair's article, Aidan Southall (1961) edited *Social Change in Modern Africa*, a collection of papers from the first 'International African Seminar' at the then college (now university) of Makarere, Uganda, held two years previously. The papers focus on diverse issues such as demography, colonization, urbanization, norms and status symbols, social networks, kinship and position of women. Southall noted in his introduction: "There are too many catchwords: detribalization, the breakdown of traditional authority, the emergence of élites and of new political and economic forces, the emancipation of women and the rise of nationalism" (p. 1).

As these quotes reveal, much concern was expressed over the impact of such changes on family cohesion and social obligation. Family care of vulnerable dependents including children, older people and those who are sick or disabled has long been portrayed both within the continent and without as a moral bedrock of African tradition, embodying orientations to reciprocity and communality in contrast to professionalised and impersonal care in

individualistic Western societies (Mair 1969, Hellman 1948, Mayer and Mayer 1961, Watson 1958). Such idealised depictions of the 'extended family' arose in the context of colonial and early postcolonial anxieties regarding 'detribalization', the decline of rural family life and the consequences for social order. After African states emerged from colonial rule and sought economic development, Marxist analyses tended to link industrialisation with a decline in family cohesion and the commodification of labour as expressed by Mair above (Meillassoux 1975, Guyer 1981). Feminists analyses in the 1980-90s continued such arguments emphasising a decline in women's status and an increase in their workload within the home and without, including the care of children and older people (Mikell 1984, Allman 1997). Historians on the other hand argued that this notion of 'retrograde steps' for African women was over-stated (Boni 2001). As cautioned by Megan Vaughan (1983), a certain 'cultural nostalgia' may be at play, as in more contemporary accounts which contrast African family care with European institutionalised care. More recently such idealisations have been challenged by the advent of HIV/AIDS which produced large numbers of orphaned children who in most cases were expected to be cared for by the extended family. Unsurprisingly several studies have revealed the limits of family care in the context of severe and epidemic illness, stigma and poverty (Morantz et al. 2013). In Seeley's memorable phrase, under such conditions family care was revealed as 'a safety net with holes' (Seeley et al. 1993).

It is not only the catastrophic impact of HIV/AIDS which has impacted on family care in sub-Saharan Africa. Indeed, in North and West Africa HIV/AIDS has not reached the epidemic proportions it has in the south and east of the continent. However the 'epidemiological transition' to non-communicable diseases such as diabetes and cancer, as well as enhanced life expectancy, presents new demands on the family to provide long-term care for disabling conditions (Beaglehole et al. 2008). In sub-Saharan Africa, the transition has in fact not occurred in the same way as elsewhere. The consequence is a 'double burden' of both

infectious and non-communicable disease provoking additional needs for treatment and care within health services and in the family home (Agyei-Mensah and Aikins 2010, Young et al. 2009). Structural adjustment in the 1980s had a profound impact on health systems in Africa which remain chronically under-funded, with severe shortages of staff (Pfeiffer and Chapman 2010). The consequence is that greater responsibility for care is moved to family members, community health workers and lay volunteers under a policy of 'task shifting' (Lehmann et al. 2009). More recently, the global economic crisis has further weakened already fragile economies, with falls in the price of commodities and rising inflation, stretching costs for health systems and household budgets alike. Such changes may influence both the capacity and the willingness of family members to provide care (Livingston 2005). Furthermore, chronic illness and disability can over time stretch material, social and psychological resources to breaking point, particularly in contexts of economic precarity (Manderson and Block 2016).

In this special issue rather than comparing cases across the continent, we focus on one country setting – Ghana. In line with intersectional approaches (Mullings and Schulz 2006) this allows us to consider differences which are constructed less along the lines of national borders or 'culture', than through the intersection of structures of inequality such as gender, age, socio-economic circumstances and access to social networks and health care. Our focus on Ghana enables us to show how social and economic changes occurring on a global scale are played out on the ground for a variety of conditions requiring care at different stages of the life course within particular urban and rural locales, while allowing for comparison and contrast with other settings. By doing so we build upon earlier studies of care in Ghana – two edited books, one on care of the seriously sick and dying (Oppong, Antwi, and Waerness 2009) and one on child care (Oppong, Badasu, and Waerness 2012), and two special journal issues. A special issue on health and health care (Van der Geest, Krause, and Senah

2012/2013) concerned family responses and help-seeking for conditions including HIV/AIDS, mental illness, and disability in children. A second focused specifically on ageing and care (De-Graft Aikins and Apt 2016). Several of the papers or chapters in these volumes touch to various degrees on changing conditions of care-giving within the family and within formal and informal health services, revealing the significance of care as a focus of social concern and research interest in Ghana and other African societies.

Perspectives on the African family as the site of care

Social, political and economic changes which intensified during the colonial period and have continued since, including migration, urbanization and the spread of Christianity and Islam, have long influenced the values and aspirations of Africans and led to new configurations of family life (Aboderin 2004). Perspectives on kinship as process and practice have questioned the classic Africanist anthropology of systems and structures. These perspectives present a challenge to an over-determined view of the family as the site of care, revealing rather the inherently precarious and dynamic nature of family life. Bourdieu's emphasis on 'practical kinship' (Bourdieu 1990) reminds us of the centrality of practical action in the making of family relationships. For Carsten relatedness as a 'continuous process of becoming connected to people' (Carsten 2000:16) is equally vulnerable to disconnection and disjuncture. The implication is that providing care is not necessarily a natural expression of family life, but an enacted achievement of human connectedness and compassion, even among those who are not biological relations (Manderson and Block 2016), as seen in the paper by Sjaak van der Geest and colleagues in this issue. As Hayley MacGregor writes in her study of families caring for relatives with mental illness in South Africa, though kin may be judged responsible for care, such responsibilities can stimulate resentment or ambivalence. Hence people invest in 'a maintenance work of kinship to ensure a safety net of support in times of incapacity' (MacGregor 2018). In this sense, care is always threaded through with conceptions of

morality and value which determine who is deserving, who is responsible and what is at stake. Understandably, therefore, requirements for care may also lead to discord and conflict in families (Sackey 2009).

Family care is always conducted within the wider context of health and social care systems, as well as local infrastructures, which determine the ways in which care is provided and supported. In the era of global health nation states are increasingly brought into international networks which shape the direction of health policy and services, for example World Health Organization directives which promote task-shifting and community-based care (WHO 2007, Bhana et al. 2010) and donor funding streams which propel NGO interventions, such as for HIV/AIDs (Seckinelgin 2005, Benotsch et al. 2004).Under these initiatives family members may be conscripted as semi-formalised 'caregivers' delivering medication or other forms of treatment or care, often under surveillance by home- or clinic-based health workers. The need for 'chronic homework' (Mattingly, Gron, and Meinert 2011) brings global policy into the heart of domestic life and can further test the ability of families to meet ethical and moral ideals in the care of others, whether these arise from communal or religious values, or from the expert directives of health professionals. Such ideals, as well as conceptions of care, disability, sickness and old age, may in turn be shaped by global influences through transnational networks of faith-based groups, NGOs and disability advocacy organisations among others, and through cross-cultural encounters resulting from the migration of family members and social and broadcast media.

Thus whilst seemingly emblematic of the intimacy of the domestic sphere, imagined as the instantiation of local kinship forms and traditional values, practices of family care are shaped and constrained by numerous extra household influences from cultural and religious values and ethics to health and welfare policy and services, and wider political and economic changes at the global, national and local levels (Das and Addlakha 2001, MacGregor 2018).

Anthropologists have coined the term ‘family assemblage’ (Price-Robertson, Manderson, and Duff 2017) to capture the way in which extra-household resources, not only human but also physical environments, policies and material objects, are co-constitutive of family life. Crucial to the concept of *assemblage*, and relevant for the papers we present here, is a focus on the ways in which forms of social life emerge and are put together, and the contestations and transformations that occur in this process. Thus rather than seeing family care as conducted within normative stable structures which are disrupted by the impingement of modern life and social change, we see family care as a dynamic process shaped by fluctuations in the resources available and the nature of the condition requiring care. Family care and illness management is imbricated with health policy and infrastructure, not just within the obvious settings of hospitals and clinics, but homes, sanitation, roads, and electricity and water supply among others. Family responses to illness, or other demands for care, are not simply a matter of acting according to affective ties, moral obligations, or ‘illness beliefs’, but are shaped by the availability and quality of these infrastructures and the possibilities for support (Feierman et al. 2010).

This calls attention to the value of ethnography to uncover over time the intimacy and intricacy of family life as enacted in practice within specific relationships and interpersonal interactions (Pinto 2009, Das and Addlakha 2001, Manderson and Block 2016). Chronic disability and sickness and the need for care can challenge kinship relations and expectations of gender and generational roles, as well as conceptions of social responsibility and ethical behaviour (Rapp and Ginsburg 2011, Livingston 2005, MacGregor 2018). Such challenges may lead to adaptation, improvisation and invention in the provision of care and the kinship ‘imaginary’ and also ignite family conflict (Mattingly, Gron, and Meinert 2011, Das and Addlakha 2001).

Family care in Ghana

By focusing on Ghana, we will highlight these diverse processes within one society which is in many ways exemplary of these processes. Urban migration has been a feature of Ghanaian society since colonial times (Hart 1973), and has continued to the present day, particularly for the young. As described earlier, from the beginning this has provoked concerns regarding the impact on family life, as well as the risks for health and social cohesion in the expanding cities. Transnational migration has also increased, both to other African states and elsewhere (Twum-Baah 2005). Migration to Britain as the former colonising power, began in the 1960s but patterns of migration have diversified and increased exponentially over the last two decades. This has resulted in a large number of 'transnational' or 'scattered' families' (Coe 2014), with members in other African states, North America and Europe, and elsewhere (Coe 2011). On the other hand, as elsewhere in Africa, family forms in Ghana have always been fluid and dynamic, changing over the life course and offering distributed forms of care according to changing needs (Coe 2014). Nonetheless, research suggests new configurations of care arising from transglobal networks created through migration, creating new access to resources and reconfiguring lines of obligation (Poeze and Mazzucato 2014, Coe 2014) . Remittances now form a significant proportion of household income in Ghana and are a valuable resource for enacting forms of care through meeting health-related expenses (Addison 2005). Migrant family members may also facilitate access to 'transnational therapy networks' (Krause 2008).

The rapid spread of Christianity, particularly forms of Pentecostalism (Gifford 2004), has also had a profound effect on the social and moral landscape in Ghana, and consequently on the practices of family care. Though Christianity has most obviously influenced the values and ideals of the nuclear family, as pointed out by authors in this issue, Christian teachings also present new interpretations of values of family reciprocity and obligation (Mohr 2013). Christian groups also provide alternative 'moral communities' for care and treatment, as

shown by Coe (this issue) in her article on Presbyterian older people. Within Christian discourse the spiritual community creates a family network of Christian 'brothers and sisters' which provides protection against exposure to 'the dark side of kinship' (Geschiere 1997) such as witchcraft or ancestral curses.

Over the last two decades Ghana has attained significant economic growth in the region, aided by a prolonged period of political stability and business and donor investment. Investment in infrastructure has seen improvements in the road network and the building of new schools and hospitals. Significantly more numbers of health workers have been trained, both nurses and lower cadres (Saleh 2013). Public universities and new private educational institutions attract students looking for increasingly desirable careers in the public sector. This period has also witnessed the introduction of the National Health Insurance Scheme (NHIS), the first of its kind in sub-Saharan Africa, which was launched with much fanfare in 2003. Ghana's transition to middle income status in 2011 seemed to mark a high point in the country's status as exemplary of 'Africa rising'[1]. However this progressive narrative has recently been subjected to some reappraisal. Economic growth has not translated into significant employment opportunities, particularly for the young and lower-skilled (Honorati and Johansson de Silva 2016), and there is evidence of widening inequality, particularly between the north and south of the country. The global recession, falls in commodity prices, fiscal restructuring and administrative mismanagement has led to economic deficit and a funding crisis for public services, including health (Molini and Paci 2015). The NHIS has struggled to maintain its viability (Alhassan, Nketiah-Amponsah, and Arhinful 2016), and there is evidence that the poorest are least likely to enrol (Kotoh and Van der Geest 2016). It is increasingly common for health services to charge families for basic materials such as

[1] The term 'Africa rising' has been widely deployed to reflect optimism about the growth in African economies, as in a 2011 article by the Economist http://www.economist.com/node/21541015

gloves and detergents as well as medicines since allocated budgets fall short of the costs of care and NHIS reimbursements are delayed (ibid). The critical question therefore is how Ghana and similar societies in low-income settings will care for their vulnerable citizens within the constraints and opportunities arising from these changes and the consequences for family relationships and the person receiving care.

Drawing on empirical examples this special issue considers how these social, cultural and economic changes have impacted on the context and practice of family care in Ghana. The papers cover a diverse range of care requirements across the life span, from the care of children and older relatives, to family and professional management of chronic health problems, such as severe mental illness, cancer and HIV. Papers trace historical trajectories of care practices, changes in family care arising from urbanisation and migration, the intersection of family care with biomedical and other forms of treatment, such as traditional or faith healing, and the introduction of professionalised models of care provision such as care homes for older people. Authors include those based in Ghana and elsewhere and range from junior to senior scholars.

The articles

Ursula Read and Solomon Nyame consider the particular challenges of family care for severe mental illness in a region which until recently had virtually no community mental health workers and lies far from the country's psychiatric hospitals. Community care within the family has gained particular prominence in relation to mental health, advocated as a rejection of institutionalisation and human rights violations of persons with mental illness, yet critiqued as an abdication of state responsibility, shifting care to communities and families without the necessary resources (Thornicroft et al. 2010, MacGregor 2018). The shift towards community-based care has been widely promoted in the treatment of people with mental

illness since the move to ‘deinstitutionalisation’ in the 1960s and this policy has been reinvigorated over the last decade under the banner of ‘global mental health’. In Africa, where until recently mental health services have largely been limited to a few scattered colonial era asylums, this vision has been little realised (Hanlon, Wondimagegn, and Alem 2010). Nonetheless a kind of de facto community care exists in so far as most persons with mental illness continue to live with the family, a factor which has been presumed to lead to better outcomes compared to high-income countries (Craig et al. 1997). Ghana is among the few sub-Saharan African states which has established system of community-based mental health care delivered by Community Psychiatric Nurses (CPNs). In recent years the country has also trained new cadres of community mental health workers tasked to work with families to support people with mental illness living at home (Agyapong, Farren, and McAuliffe 2016). However Read and Nyame provide rich ethnographic description of what is at stake in the day-day reality of providing long-term care for someone living with a profoundly stigmatised and puzzling disorder. They paper describe the moral imperative as creating particular expectations on women who carry the most responsibility for day-to-day care, but frequently do so without the support of husbands or the wider family. With increasing numbers of female-headed households in Africa (Milazzo and van de Walle 2015), the authors suggest attention to the actual configurations of what is meant by ‘family’ and the implications for the sustainability of care. They also warn that the uneven implementation of community-based services may increase the burden on the poorest families living in the most remote communities.

The paper by Van der Geest and colleagues concerns HIV/AIDS and, as with Read and Nyame’s paper, shows how the nature of the problem obstructs the provision of family care. Like mental illness, HIV/AIDS is a stigmatised condition associated with morally transgressive behaviours. Like mental illness, home-based care is also widely promoted,

particularly as HIV has moved from an acute infection to a chronic condition. However Van der Geest and colleagues' research shows that the stigmatised nature of HIV/AIDS prevents disclosure within the family, and leads those affected to form new care networks, not with family, but with health professionals. This case study, along with Van der Geest's earlier work on ideals of reciprocity in relation to care of older people (van der Geest 1997), shows how family care is deeply permeated with moral judgements which decide who is deserving of care. Family networks face increasing burdens of care as parents live longer, or with chronic conditions, or, as a result of migration, potential carers live at a greater distance. In this context the values which inform concepts of reciprocity can become increasingly powerful in deciding how limited family resources are distributed. The discourse of witchcraft may thereby gain more, and not less salience, particularly given the ways in which this has been taken up by Pentecostal churches (Meyer 1992, Onyinah 2002).

Drawing on her own research over several decades, as well as the ethnographic record and recent research by Ghanaian colleagues, Christine Oppong traces the impact of social, political and economic changes on baby care. She argues that despite economic growth in Ghana, child under-nutrition remains high, and that the weakening of 'customary solidarities' and wider kin networks through migration and changes in working life and family structure, has reduced the pool of potential carers for young babies. Like Read and Nyame, Oppong highlights the ways in which this dispersal of the social network concentrates caring responsibilities on the mother. As has been shown elsewhere (Lewis 2001), in industrialised economies women now face a double burden in meeting competing demands of work and caring responsibilities, whether for children or older parents. Since many women in Ghana no longer live in extended family households and increasingly work outside the home, this has a significant impact on the amount of time and attention mothers can provide to their babies, in particular their ability to breastfeed on demand as recommended by WHO. Oppong makes

the important point that initiatives which rely on education to improve breast-feeding practices, and ignore the impact of the social and economic context on women's caring capacity, evade the real cause of the problem and so will have limited success. Most women in Ghana work in the informal economy which means they are not entitled to maternity leave, nor any other form of social security. This economic precarity can have a profound effect on their caring capacity and ultimately on the health of their children. However, as Oppong points out, it is not only the children of poorer women who are affected. For women who work in the formal sector, there is limited flexibility in working hours, which can also impact on the capacity for care.

The final paper in this special issue by Cati Coe concerns the other end of the life course, by considering care of older people. With a global aging population, including in Africa, with many living with disabling chronic conditions, care of older people has become of increasing concern. Coe's research adds to a strong body of research on care of older people in Ghana (Aikins et al. 2016). Like baby care, care of older persons has traditionally been considered one of the distinguishing values of African societies. Coe's work is an important reminder of the fragility of such care in the face of social change. While institutional rather than family care of children or older people is often viewed as a moral failing of Western societies, as both Oppong and Coe point out, these changes often have less to do with culture than with the demands of the political economy. Coe suggests that older people's imaginary of institutional forms of care is not so much an argument for replacing family care, but a means of critiquing its failings. Like Oppong, Coe reports that migration and the dispersal of family networks have had a detrimental effect on families' capacity to care, this time for older kin. Coe's research focuses on the role of the Presbyterian church in providing day care for older people, an important reminder of the potential of religious institutions as forms of 'fictive' family, and their significant role in providing forms of health and social care in many African

settings (Olivier et al. 2015). Echoing colonial reification of African family tradition, Coe shows how government policy in Ghana reflects moral ideals concerning family care of older people but thereby neglects to acknowledge the impact of social and economic change on family capacity for care. Faced with the deficiencies of family care, but without any alternative, older people imagine the possible role of the state in making up the care deficit through the provision of institutional care.

Taken together these papers illustrate the challenges for families in Ghana and across the African continent, in meeting the needs for care from young, old, mentally and physically unwell members alike. The difficulties of providing care of dependent family members, whilst always present, now faces changes which cross the global, national and local and range from shifting epidemiological patterns, to neoliberal health system reforms, to urban and international migration. These changes have been particularly acute in African societies, characterised by high levels of out-migration, weak economies and fragile health systems, alongside increasing needs for long-term care. These papers illustrate both the continuing moral force of the ideal of family care in Africa, as well as the considerable difficulties in meeting this ideal in the face of these changes. This suggests that it is not only older people who need to imagine alternatives, in Coe's words, 'beyond kin care'. Nonetheless, the family in Africa, as everywhere, remain vital as caregivers, whether for young adults with mental illness, sick relatives, dependent children or older people with physical limitations. It is widely acknowledged that family care facilitates social inclusion and enables the continuation of social ties, making family care the preferred option for most (Repper and Perkins 2003). These papers suggest however that the viability of such family care will be increasingly under threat without addressing the causes and consequences of increasing global mobility, precarity and inequality which have some of the biggest impacts in Sub-Saharan Africa.

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